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The Average Size of American Families

THE simple question, "What is the average size of American families?" is, oddly enough, a difficult one to answer. As a matter of fact, there is no single answer, for the figure will depend upon the manner in which the family is defined.

The Bureau of the Census, in its decennial enumerations of the population in 1930 and 1940, defined a private family as comprising "a family head and all other persons in the home who are related to the head by blood, marriage, or adoption, and who live together and share common housekeeping arrangements. A person living alone is counted as a one-person private family." Thus, the census family may include married children, sisters, brothers, cousins, aunts, and other blood relatives and in-laws. On this basis the Census Bureau found that in 1940 the average family in this country consisted of 3.50 persons. This figure was found simply by dividing the total number of families enumerated into the total number of people living in these families, excluding lodgers, servants, and other unrelated persons.

Of greater interest than the average size of family as defined by the census, which includes one-person families, is the average for families consisting of two or more persons, for, in these instances, we have a measure of the responsibility of the family head. Thus, it is found that in 1940 the average size of families consisting of two or more persons was 3.79. The average varies, of course, according to the marital status and age of the family head. For example, for families in which husband and wife are living together, either with or without children or other relatives, the average is 3.86. This is appreciably in excess of the average for families headed by men of other marital status—that is, men widowed, divorced, separated, or single. For this category, the average was 3.39 persons, a figure practically identical with that for families headed by women.

More meaningful than any overall figure is the variation in size of family according to the age of the family head. Such data, shown in the table on page 2, are available only for families where husband and wife live together. These families, which are commonly regarded as natural or "normal" families, comprise more than five sixths of all

AVERAGE SIZE OF FAMILIES* CLASSIFIED ACCORDING TO MARITAL STATUS OF FAMILY HEAD, AND PERCENT OF SUCH FAMILIES WITH CHILDREN UNDER 21 PRESENT. UNITED STATES, 1940

MARITAL STATUS, SEX, AND AGE OF FAMILY HEAD	AVERAGE SIZE OF FAMILY,* PERSONS	PERCENT OF FAMILY HEADS OF SPECIFIED STATUS WITH CHILDREN UNDER 21 PRESENT
All Families	3.79	55.7
Male Head	3.84	59.3
Married, wife present	3.86	63.6
Under 35	3.46	68.5
35–44	4.28	79.4
45–54	4.27	68.9
55 and Over	3.48	36.2
Other marital status†	3.39	21.6
Female Head†	3.38	35.5

*Excluding families consisting of one person living alone.

†These families may be headed by a person widowed, divorced, or separated from his or her spouse, or by a person still single.

families with two or more persons enumerated in the 1940 census. In natural families where the husband was under 35—families of fairly recent origin for the most part—the average was 3.46 persons. As the family grows older, this number increases and reaches a maximum of 4.28 persons when the husband is in the age period 35 to 44 years, an average which is continued in the next age group, 45 to 54 years. Beyond this, the family size diminishes, the average being reduced to 3.48 at ages 55 and over.

These changes in family size are readily explained. During the age period of family formation, the average is increased by births to families without children, and by additional births to families which already have children. As may be seen in the last column of the table, the proportion of families with children under age 21 present rises from a little more than two thirds where the husband is under 35, to a maximum of four fifths where he is in the age group 35 to 44. After this period of growth, the family begins to decrease in average size as an increasing proportion of children attain independence. Only a little more than one third of the families in which husbands are 55 and over have children under 21 still with them; and some of these are adopted children, stepchildren, or even grandchildren.

A very substantial proportion of the population in family households is made up of children and grandchildren of all ages. Altogether, they constituted more than two fifths of the entire population in our families in 1940; their number was 53,700,000.

Practically one fifth of these children were at ages under 5 years, with like proportions at ages 5 to 9, 10 to 14, and 15 to 19; one tenth were at ages 20 to 24, and another tenth at 25 and over.

The facts clearly exhibit the concentration of family burdens and responsibilities around midlife. They indicate the necessity for the head of the family to prepare for these responsibilities before reaching the age at which they become a maximum. Such preparation involves not only the accumulation of assets and the purchase of a home, but also the planning of a Life insurance program to protect the dependents in case of the untimely death of the breadwinner.

Decline in Mortality Among Women in Wartime

THERE has been an extraordinary response from the women of our country to meet the war needs. Well over 200,000 of them have entered the armed services as nurses, and as WACS, WAVES, SPARS, and Marines to relieve men for combat duty. The number of women workers in this country has increased in the past four years by 6,000,000 to fill the gaps left by men in their civilian employment, and to meet the vastly expanded wartime production and services. At the end of last year there were 17¼ million women employed in the United States, constituting one third of the total labor force. In addition, many thousands of women have been carrying on a variety of vital activities, without remuneration, in the Red Cross and in a number of other voluntary organizations.

The participation of women in the war effort has created some anxiety as to its possible effects on their health. The large majority of women who entered the labor force were inexperienced. More than half had left their homes to take gainful employment, while almost one third of the new workers came from school or college. Moreover, a great many of them took jobs, traditionally held by men, in the manufacture of chemicals, rubber, ships, tanks, planes, guns, and other weapons of war. Although women were not set to do the most laborious and hazardous tasks in these industries, many of them were, nevertheless, subject to greater hazards than they had met in their ordinary pursuits in peacetime years.

In view of this situation, it is extremely gratifying to find that mortality among women in the main working ages of life has declined during the war period. The improvement is clearly indicated in the table on page 4, which shows the year-by-year death rates among white females, ages 15 to 54 years, insured in the Industrial Department of the Metropolitan Life Insurance Company. The specific causes listed in the table account for three fourths of the total deaths at these ages. Between 1939 and 1944 the death rate from all causes com-

bined among these women fell by one sixth, the rates dropping from 327.5 per 100,000 to 274.5. The record for tuberculosis is a particular source of satisfaction, in view of fears that had been entertained regarding possible unfavorable effects of wartime living and working conditions. In 1939 the death rate from tuberculosis among these insured women was 35.0 per 100,000; by 1944, it had declined by more than one fifth to 27.0. Similarly, the diseases of the heart, arteries, and kidneys, despite the strains of war, show a decline of 13 percent in mortality during this period.

From time to time, concern has been voiced regarding the health of the large number of women who work while they are pregnant. However, the death rate from diseases of the puerperal state among these insured women decreased by almost one third between 1939 and 1944, even though the birth rate increased markedly. Much of the improvement, of course, is attributable to the remarkable effectiveness of the sulfa drugs in the treatment of puerperal septicemia, and to better prenatal and postnatal care. Even cancer, the leading cause of death among women in the ages 15 to 54, fell by 8 percent in this five-year period, which may indicate that women are seeking diagnosis and treatment earlier in the course of the disease. Because of cyclical variations in mortality, influenza and pneumonia do not show a consistent downward trend, although the death rates from these diseases were on a much lower level in 1944 than in 1939, both years affected by widespread epidemics. The death rate

STANDARDIZED* DEATH RATES PER 100,000 FOR WHITE FEMALES AT AGES 15 TO 54 BY SPECIFIED CAUSES, 1939 TO 1944. WEEKLY PREMIUM-PAYING INDUSTRIAL BUSINESS. METROPOLITAN LIFE INSURANCE COMPANY

CAUSES OF DEATH	1944‡	1943	1942	1941	1940	1939
All Causes—Total	274.5	288.1	298.0	292.8	310.2	327.5
Influenza	2.9	2.1	1.5	2.8	2.6	4.1
Pneumonia (all forms)	8.6	9.3	8.0	8.2	9.2	14.6
Tuberculosis (all forms)	27.0	29.4	29.4	31.0	33.6	35.0
Cancer (all forms)	53.5	55.3	59.5	56.8	56.2	58.0
Diabetes mellitus	8.4	8.8	8.9	8.5	9.4	9.1
Cerebral hemorrhage	16.3	17.5	18.1	15.1	17.2	17.4
Diseases of the coronary arteries and angina pectoris	10.5	10.3	11.2	9.5	10.1	9.1
Other chronic heart diseases†	39.1	45.2	46.6	42.6	47.3	48.1
Chronic nephritis	14.6	15.9	17.1	16.3	17.3	18.2
Puerperal state—total	11.2	12.3	13.9	13.9	13.7	16.3
Accidents—total (exclusive of enemy action)	12.3	10.9	13.1	13.9	13.5	12.8

*Standardized for age on the basis of the Standard Million, England and Wales, 1901.
†International List (1940) titles 92, 93 (*c*), (*d*), (*e*), and 95.
‡Provisional.

from accidents moved rapidly upward until 1941, but with the restrictions in the use of automobiles, the mortality showed some improvement during the next two years. Deaths from occupational accidents in this group of white women are still very small in number, although fatalities have increased as the number of women employed has risen.

Altogether, the wartime mortality record of American women is very satisfactory. It undoubtedly reflects, to a large extent, the protective measures instituted to guard the health and safety of women workers, and the care taken in placing women in jobs which are not beyond their physical capacity and skill. Large numbers of women in sedentary jobs are subject to practically no unusual hazard. Those who have gone into the more strenuous employments in the shop and factory have, for the most part, been placed on the relatively simpler operations. For example, many are now working on drill presses, or they do light riveting or electric welding, assembling of small machines, repairing of airplanes, inspecting, and packing.

The employment of many millions of women in business and industry has naturally led to the development of new practices in industrial hygiene and safety, as well as to the expansion and the more vigorous enforcement of existing safeguards. As a result, many more plants than ever before have definite safety programs, women's rest rooms, and medical services; there are restrictions against having women lift heavy objects, and rules regarding the clothing to be worn by them on the job. In many instances, the care of pregnant women who remain at work follows special recommendations offered by the United States Department of Labor. In addition, there are the substantial benefits derived by wives of enlisted men under the Emergency Maternity and Infant Care program inaugurated by the Federal Government. The concentrated attention on the welfare of women at work, and more particularly their increased earnings and improved standards of living, have had a beneficial effect upon their health and mortality. There is no reason why this favorable situation should not continue.

Home Accident Fatalities Increase Among Preschool Children

THE marked increase in the death rate from home accidents among children of preschool age clearly indicates that greater attention should be given during the war period to safety in homes where young children are present. Among boys and girls 1 to 4 years of age, insured in the Industrial Department of the Metropolitan Life Insurance Company, the death rate from home accidents in the years 1942 to 1944 averaged 23.4 per 100,000, or about two fifths higher than the average for the three prewar years 1939 to 1941. This rise in the accident rate

is the more serious because the recent high birth rates have added a large contingent of children of preschool age to the general population.

A reason for this increase in mortality from accidents is not difficult to find. Many of the children, because of wartime conditions, are deprived of the safeguards that they enjoy in their homes in normal times. In families where the mother goes out to work, the youngsters too often are left in the care of brothers and sisters who themselves are still quite young; or the children may be left in the care of a neighbor who already has all she can do to look after her own family. Young children need the watchful eye of a mother in safeguarding them against the many home hazards.

Accidents in and about the home take a considerable toll of life each year among children of preschool age in the United States. In 1942, the last year for which official information is available for the general population, there were about 4,400 deaths from accidents of all kinds among children at ages 1 to 4. More than half of this total, or about 2,500, it is estimated, occurred in the home. Of the home-accident fatalities, about 1,300 were caused by burns and scalds, 350 by the ingestion of poison-containing compounds, about 250 by falls, and 100 each by drowning and firearms.

Fatal burns among children of ages 1 to 4 years, are caused in about equal numbers by hot liquids and by open flames or hot objects. Fewer children would be scalded if they were kept out of the kitchen or other rooms where the mother is working with hot liquids. A large proportion of the children fatally scalded are injured when they fall into vessels of hot or boiling fluids used for cleaning purposes, or when they pull on tablecloths and bring down upon themselves containers of hot liquids. Pots and pans which are accidentally dropped on youngsters because of broken handles, add to the toll. Although wartime shortages may make it difficult to repair or replace prized utensils, they should be discarded in favor of more sturdy, even if less desirable, substitutes.

Now more than ever it is necessary to keep children from playing with matches, since the current scarcity of strike-on-box and of book or safety matches has resulted in wider use of the strike-anywhere or kitchen matches. Children playing with any kind of matches are likely to set fire to their clothing or to start a conflagration, and the strike-anywhere type presents a special hazard. All matches should be kept in a safe place, preferably in a metal box out of the reach of children. Playing around stoves and grates is another important cause of fatal burns among youngsters.

Medicines, drugs, cleaning compounds, fuels (kerosene), disinfectants and insecticides, are the principal substances causing fatal poisoning among preschool children. The spring cleaning period following the season of respiratory and other winter ailments, is a particularly good time to look over the accumulated drugs

and medicines, and to discard those no longer needed. The items that are retained should be properly labeled and placed in a locked cabinet. Insecticides, rat poisons, cleaning fluids, and other poisonous substances should be stored where children cannot get at them.

The large number of accidental falls among young children are due, for the most part, to slippery floors, unanchored small rugs, rugs with curled edges, loose stair carpets, wet or greasy steps, and objects left on steps. Low and unguarded windows are also responsible for an appreciable number of fatal falls among preschool children.

Death Toll Highest in Winter in Both Hemispheres

OUR winter peak in mortality is characteristic not only of the United States, but also of most other countries with about the same kind of climate. This similarity in the broad outline of seasonal mortality extends also to countries in the temperate zone of the southern hemisphere, due regard being had to the reversal of summer and winter in their relation to the calendar. Some of the detailed statistics relating to mortality month by month, throughout the calendar year, are exhibited in the table on page 8, which shows the daily average of deaths for each month as a percent of the daily average for a three-year period, for 22 countries. In 16 of these the mortality reaches its peak in the winter months; in four countries—Finland, Denmark, Bulgaria, and Chile—the maximum comes a little later, in the spring. Mexico and British India, both of which are faced with special health problems, deviate even more from the usual pattern. In Mexico the highest death rates of the year are recorded in summer, and in British India the peak comes in autumn.

The contour of the monthly mortality curve in the respective countries depends, of course, upon the seasonal distribution of the more important causes of death. The winter peak is such common phenomenon because the respiratory diseases play a large role in determining the shape of the curve in most countries. These diseases, including influenza and pneumonia, take a heavy toll of life during the winter, and in addition they contribute toward causing death of many persons suffering from serious chronic diseases. Summer, on the other hand, is the season of most favorable mortality in the large majority of countries with modern medical and health services.

In areas where health conditions are substandard, the curve of mortality, in addition to a cold weather peak, shows a secondary crest in the summer. This is the case in Italy, Rumania, Bulgaria, and Japan. In these countries the warm weather brings an increase in the loss of life from the diarrheal and other intestinal diseases. To some extent the summer bulge in the mortality curve reflects the high infant mortality of

summer where sanitary conditions are poor. In the four countries listed, the infant mortality in prewar years was from two to more than three times that for the United States. In Mexico, where public health and sanitation are far below the standard in our own country, and where winters are relatively mild, the curve of general mortality reaches its highest point in the summer months. This situation results in part from the fact that the diarrheal diseases rank first among the causes of death in Mexico.

Inasmuch as mortality statistics for British India are of doubtful validity, and so large a variety of diseases are prevalent there, it is difficult to determine with assurance what causes account for the unusual seasonal curve of mortality in that country. It appears, however, that the maximum mortality in the autumn reflects, in part at least, the high toll from malaria in these

DAILY AVERAGE NUMBER OF DEATHS IN EACH MONTH AS PERCENT OF DAILY AVERAGE IN THE PERIOD 1936–1938, IN SPECIFIED COUNTRIES

COUNTRY AND AREA	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
Northern Hemisphere												
North America												
United States	114	117	110	105	97	93	95	88	87	94	97	105
Canada	109	113	110	106	102	94	92	88	94	95	97	101
Mexico	88	90	95	104	104	111	109	114	104	97	94	91
Europe												
Finland	107	111	111	127	113	100	91	80	83	88	89	101
Sweden	111	116	115	112	105	100	89	85	85	91	93	101
Denmark	111	108	110	114	114	103	87	85	83	89	91	105
England and Wales	132	124	116	104	97	88	82	80	82	89	96	111
Scotland	134	118	113	103	95	92	83	81	82	87	99	115
Belgium*	109	116	118	109	102	94	85	83	84	96	96	109
Switzerland	114	112	117	110	103	95	89	85	85	91	96	105
Austria*	113	116	111	106	102	93	89	86	84	95	98	108
Hungary	105	110	112	110	104	95	96	97	91	95	88	97
Italy*	127	117	104	92	90	94	101	91	84	90	95	116
Rumania	103	107	109	107	95	85	99	108	95	97	94	102
Bulgaria	102	105	113	123	99	85	98	100	88	90	94	105
Asia												
British India*	100	92	90	98	98	95	91	99	103	103	110	121
Japan	114	117	106	95	89	90	101	107	101	93	90	97
	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE
Southern Hemisphere												
South America												
Chile	94	100	109	114	111	117	112	104	90	82	81	86
Uruguay	103	110	107	97	103	107	102	97	93	90	90	91
Oceania												
Australia	120	115	109	96	96	92	90	90	89	93	98	110
New Zealand (Except the Maoris)	122	122	114	111	103	81	86	89	89	89	100	108
Africa												
Union of South Africa (White population)	113	109	107	98	100	100	94	87	91	94	102	107

*Data for years 1936–1937.

months; another factor may be the high prevalence of the intestinal diseases in the summer and autumn. In India, as in Mexico, the dry season which comes in the colder months is the most favorable period.

The seasonal distribution of mortality is not a constant phenomenon but varies with changes in epidemiological conditions. For instance, in years when respiratory diseases take an exceptionally heavy toll of life, the general death rate from other causes also rises to higher than usual levels in the winter or early spring. The seasonal curve of mortality may also be temporarily, though materially, modified by some catastrophic event, such as a major war or a widespread epidemic. When the memorable influenza pandemic was raging in the fall of 1918, the usual pattern of seasonal mortality was completely distorted, the general death rate reaching an excessively high peak in October of that year. In addition to these temporary changes in the seasonal variation of mortality, there may be long-term permanent modifications in the character of the curve. Improvements in sanitation in a number of our cities, including, for example, New York and Chicago, have in the last 50 years or so completely reversed the seasonal curve, the point of maximum mortality shifting from the summer to the winter months. It may well be that recent medical advances, such as the use of the sulfa drugs and penicillin, will further modify the contour of the seasonal curve.

Why Do People Kill Themselves?

SUICIDE takes a high toll of life annually in our country. In some years as many as 20,000 people inflict death upon themselves, and even during the current war period, when suicide has declined to the lowest point on record, the year's total still comes to about 13,000. In addition to this deplorable waste of life, there are tens of thousands more who find life so difficult that they attempt suicide, although unsuccessfully. Here is a challenging problem which merits greater attention from the agencies and institutions concerned with life conservation and human welfare.

Why is it that so many people make attempts on their lives in the face of the natural urge to live, their obligations to family and society, and the prevailing mores sanctioned by church and State? The motives for self-inflicted death frequently cannot be determined with accuracy, for in many cases suicide notes or other sources of information tend to conceal rather than reveal the true reasons for the act. There are, however, some pertinent data available which provide an insight into the circumstances leading to suicide. It is well known, for example, that the suicide rate tends to vary inversely with the curve of business conditions, indicating that financial difficulties are frequently a motive for self-destruction. But in recent

years jobs have been plentiful and well paid, and business has been booming, with the result that the economic motive has been largely eliminated. According to data published by the Police Department of Detroit, Mich., less than 2 percent of the suicides in that city during 1942 and 1943 were attributed to financial difficulties; and it is likely that a similar situation exists in the country as a whole. Nevertheless, as already noted, there are still about 13,000 suicides a year in the United States, and several times that number of persons who make an ineffectual attempt to die by their own hand.

What, then, are the motives for suicide during a period when favorable economic conditions prevail? The experience in Detroit, covering the years 1942 and 1943, indicates that there are marked differences according to sex. Among males, ill health ranks as the leading motive, accounting for nearly 40 percent of all attempts at suicide, whether successful or not. About 30 percent of the attempts are attributed to domestic difficulties, and only 4 percent to love affairs. Among women, however, affairs of the home and the heart play a much larger role than among men. Domestic troubles are given as the motivating cause in about half the attempts at suicide among women, and love affairs contribute a little more than 10 percent. Ill health ranks second in numerical importance, accounting for about one fifth of the cases. In each sex, general despondency and the death or illness of others are responsible for a number of suicides annually.

Of special interest is the relation between the motive for suicide and the frequency with which the attempt is successful. According to the recent experience in Detroit, the highest proportion of successful attempts, in each sex, is found among those who take to suicide because of ill health. Among men, half the number of the attempts at suicide for reasons of health are successful, and among women the proportion is about one quarter. Domestic difficulties and love affairs show a much lower proportion of successes, particularly among women. Only 14 percent of the attempts by men because of family worries are successful, and about 10 percent of those motivated by love affairs. Among women, of the attempted suicides because of domestic difficulties, only 2 percent are successful, and of 114 attempts attributed to love affairs in the two years under review, only one succeeded. It would appear from these facts that unhappy lovers do not choose efficient methods of taking their lives, either because they are too disturbed or, more likely, because they simply wish to create a dramatic situation.

The motives for suicide are so many and so varied that the problem obviously cannot be solved through any one method or approach. The responsibility for this task must lie with our social institutions, the mental hygiene movement, and the broad field of medicine.

Comparative Data on the Causes of Death Among Industrial Policyholders

The following table shows the mortality among Industrial policyholders for January 1945 and January 1944, together with the death rates for the years 1944, 1943, and 1942.

DEATH RATES* PER 100,000 POLICYHOLDERS FROM SELECTED CAUSES
WEEKLY PREMIUM-PAYING INDUSTRIAL BUSINESS
METROPOLITAN LIFE INSURANCE COMPANY

CAUSES OF DEATH	ANNUAL RATE PER 100,000 POLICYHOLDERS*				
	January 1945	January 1944	Year		
			1944	1943	1942
ALL CAUSES—TOTAL	876.8	978.2	827.0	778.6	732.9
—Excluding war deaths	*772.0*	*957.1*	*758.4*	*764.1*	*728.4*
Typhoid fever	0.3	0.5	0.2	0.3	0.4
Measles	.1	1.2	.7	.6	.5
Scarlet fever	.1	.4	.4	.4	.4
Whooping cough	.9	.7	.6	1.3	1.0
Diphtheria	1.2	1.0	.7	.7	.6
Influenza	5.3	42.0	8.3	6.1	4.3
Pneumonia (all forms)	37.8	80.9	33.4	35.1	29.2
Tuberculosis (all forms)	35.8	42.3	39.3	40.1	41.7
Tuberculosis of respiratory system	32.2	38.4	35.7	36.3	37.6
Syphilis	10.0	11.3	9.3	10.0	10.6
Cancer (all forms)	104.4	105.6	108.5	106.7	106.1
Diabetes mellitus	27.3	38.0	27.6	28.5	28.0
Cerebral hemorrhage	67.6	75.3	65.4	65.5	60.4
Diseases of the coronary arteries and angina pectoris	73.8	72.7	63.0	60.5	57.7
Other chronic heart diseases†	166.2	219.5	162.4	168.4	156.6
Diarrhea and enteritis	3.4	2.6	4.7	4.5	4.4
Appendicitis	3.5	5.0	5.4	5.5	5.9
Chronic nephritis	46.8	54.7	45.9	50.6	49.4
Puerperal state—total	3.7	3.4	4.1	4.2	4.5
Suicides	5.1	5.5	6.0	6.5	7.3
Homicides	2.4	2.5	2.9	3.5	3.8
Accidents—total	52.0	51.0	53.6	51.4	48.6
Home accidents	8.6	10.8	10.3	11.9	11.4
Occupational accidents	4.1	4.5	5.6	6.7	7.1
Motor vehicle accidents	13.8	14.9	13.9	13.3	16.7
War deaths (enemy action)	104.8	21.1	68.6	14.5	4.5
All other causes of death	124.2	140.8	115.8	113.9	107.1

*The rates for 1944 and 1945 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†International List (1940) titles 92, 93 (c), (d), (e), and 95.

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STATISTICAL BULLETIN
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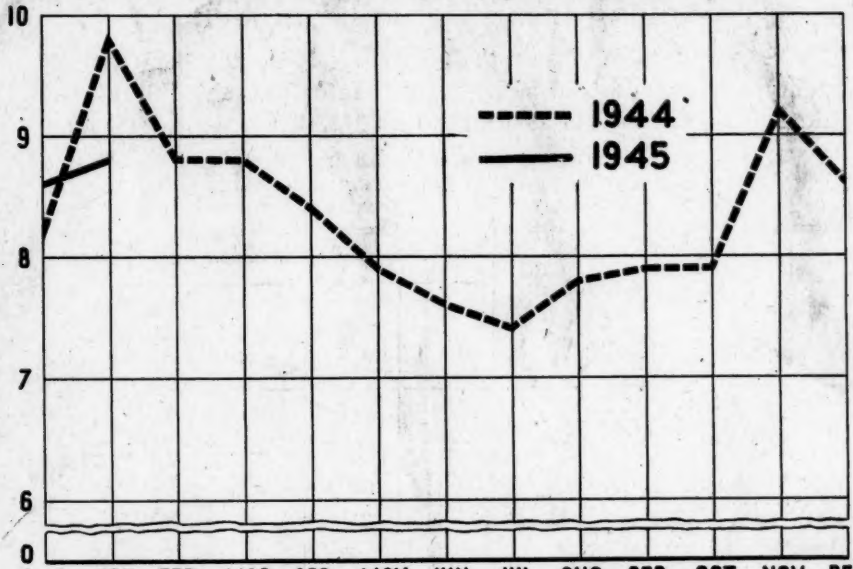
MORTALITY FROM ALL CAUSES

METROPOLITAN LIFE INSURANCE COMPANY
INDUSTRIAL DEPARTMENT, WEEKLY PREMIUM-PAYING BUSINESS

DEATH RATES PER 1,000 ANNUAL BASIS (*1944 and 1945 figures are provisional*)



(DEC)	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1944	9.8	8.8	8.8	8.4	7.9	7.6	7.4	7.8	7.9	7.9	9.2	8.6
1945	8.8											

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